Applicant Tracking Worksheet

(use additional sheets, if necessary)

Name_____ DOB_____ SSN_____

Phone_____ Address_____

Third Party Contact (N/A if no one)_____

Third Party Phone_____ Third Party Address_____

Area of town where person stays_____

Food kitchens/shelters/etc._____

Other staff/programs involved_____

Program/Staff person_____

Protected filing date_____

Application date_____

☐ By Phone ☐ In Person

SSA Claims Representative

Name_____ Phone_____

Office address _____

Medical evidence submitted with application? ☐ Yes ☐ No

Medical records sent for:

Source _____

Date(s) requested_____ Date received_____ Date sent to SSA/DDS _____

Source _____

Date(s) requested_____ Date received_____ Date sent to SSA/DDS _____

Source _____

Date(s) requested_____ Date received_____ Date sent to SSA/DDS _____

DDS Disability Examiner

Name_____ Phone_____

Dates of follow-up contact with DDS examiner_____

Consultative examination appointment? ☐ Yes ☐ No If yes, Date _____

Decision ☐ Approved ☐ Denied Date_____

Reconsideration filed (N/A if person is approved)_____